IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
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CERTIFIED MAIL: 7003 0500 0003 1967 2890

August 23, 2006

Jeffrey F. Hill, Administrator
Life Care Center of Coeur d'Alene
500 West Aqua Avenue
Coeur d'Alene, ID 83815

Provider #: 135122

Dear Mr. Hill:

On **August 11, 2006**, a Recertification survey was conducted at Life Care Center of Coeur d'Alene by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency in your facility to be isolated deficiencies that constitute actual harm, but are not an immediate jeopardy, as evidenced by the attached CMS Form 2567L whereby significant corrections are required.

Enclosed is a Statement of Deficiencies/Plan of Correction, CMS Form 2567L, listing Medicare/Medicaid deficiencies, and a similar form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **Please provide ONLY ONE completion date for each Federal/State Tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance. After each deficiency has been answered and dated, the administrator should sign both the CMS Form 2567L and State Statement of Deficiencies, in the spaces provided, and return the originals to this office.**

Your Plan of Correction (PoC) for the deficiencies must be submitted by **September 5, 2006**.

Failure to submit an acceptable PoC by **September 5, 2006**, may result in the imposition of civil monetary penalties by **September 25, 2006**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

This agency is required to notify CMS Region X of the results of this survey. We are recommending that CMS impose the following remedy:

Denial of payment for new admissions effective as soon as notice requirements can be met. [42 CFR §488.417(a)]

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **February 11, 2007**, if substantial compliance is not achieved by that time.

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0036, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach1.pdf

This request must be received by **September 5, 2006**. If your request for informal dispute resolution is received after **September 5, 2006**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

Loretta Todd

LORETTA TODD, R.N.
Supervisor
Long Term Care

LT/dmj

Enclosures

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 135122	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 8/11/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE OF COEUR D'ALENE	**500 W AQUA AVE COEUR D ALENE, ID**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 278	483.20(g) - (j) RESIDENT ASSESSMENT

The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview it was determined the facility did not properly code the advanced directive portion of the MDS for 1 of 23 (#8) sampled residents. The findings include:

Resident #8 was admitted to the facility on 7/03/06 with diagnoses of urinary tract infection and status post cerebral vascular accident with left sided weakness.

The resident's resuscitation status form, signed by the resident on 7/03/06 stated, "Resuscitation constitutes an extraordinary measure and SHOULD be done on this resident in case of extreme emergency."

The admission MDS for the assessment date of 7/10/06 and the Medicare 30 day MDS for the assessment date of 7/31/06 both indicated the resident's choice was "Do not resuscitate."

The social worker who had completed the advanced directive portion of the MDS was interviewed on 8/10/06 at 11:40 am. The social worker stated, "it was an entry error." She agreed the resident was a full code.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135122	A. BUILDING _____ B. WING _____	08/11/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE OF COEUR D'ALENE	500 W AQUA AVE COEUR D ALENE, ID 83815

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F 000	INITIAL COMMENTS The following deficiencies were cited at the annual recertification survey at your facility. Surveyors conducting the annual survey were: Barb Franek, RN, BSN, COHN-S, Team Coordinator Lorna Bouse, BSW Lea Stoltz, QMRP Kim Heuman, RN Tom Snyder, RN Survey Definitions: MDS = Minimum Data Set assessment RAI = Resident Assessment Instrument RAP = Resident Assessment Protocol DON = Director of Nursing LN = Licensed Nurse RN = Registered Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record	F 000	This Plan of Correction is submitted as required under Federal and State regulations and statutes applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility and such liability is hereby specifically denied. The submission of this Plan of Correction does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the scope and severity regarding the deficiency cited is correctly applied. RECEIVED SEP - 5 2006 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	CEO	9-1-06

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 167 SS=C	483.10(g)(1) EXAMINATION OF SURVEY RESULTS A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and the group interview, it was determined the facility failed to post notice of availability of the survey results. This affected 23 of 23 (#1 - #23) sampled residents and all other residents, family members or personal representatives for residents of the facility. The findings include: 1. General observations of the facility were conducted on 8/08/06 beginning at 6:30 am. A notice or some type of signage was not observed to be posted as to the location of the survey results. On 8/08/06 at 9:30 am, the DON was asked where the survey results were located. The DON indicated there was a 3 ring binder in the waiting room, off the front entrance. The surveyor went to the waiting room and found a 3 ring binder sitting on a hutch in the room. The binder was marked with a sign on the top of the binder stating, "do not remove." On the spine of	F 167 **F 167**	I. The area noted potentially affect all residents. II. The Survey Book with the most recent survey findings is located in the front lobby and clearly labeled. III. The posting of the location of the Survey Book is on each resident care wing, in addition to the front lobby area. IV. The ED will monitor for ongoing compliance. V. Completion Date: 9/18/2006 ok bf	

angela peterson RN
9-1-06

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F 167	Continued From page 2 the binder was a label indicating the binder contained the survey results. That label was not initially visible to the surveyor. During the group interview on 8/09/06 at 10:45 am, residents were asked if they knew where the survey results were located. All 20 residents and the 1 family member expressed they did not know where the survey results were located.	F 167		
F 241 SS=E	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and record review, it was determined the facility did not promote care in a manner that promoted dignity for 3 of 20 sample residents (#s 4, 11 and 14) and one random resident #24. Resident #14 was pushed in a commode/shower chair to his room with an uncovered bucket under his seat. Residents #4 and #11 had their rooms entered by staff who failed to knock first. And random Resident #24 was in the dining room with matted and messy hair. Findings include: 1. Resident #14 was admitted to the facility on 12/8/03 with a diagnosis of Alzheimer's disease. The resident's quarterly MDS, dated 7/26/06, documented he was severely cognitively impaired	F 241	**F 241** I. The facility is committed to meeting resident rights for residents #4, 11, 14 and 24. All residents have the potential to be affected. Residents have been interviewed and there were no other findings.	

9-1-06

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F 241	Continued From page 3 and required total assistance by staff for all ADL care. The resident was observed on 8/8/06 at 6:40 am. The resident was being assisted out of a shower room by one aide. The aide pushed the resident in a shower/toilet chair, out of the hall where the shower room was, across the nurses station (central to four halls on one side of the facility) and down the whole length of the next hall to the resident's room. The shower/toilet chair had an uncovered incontinence bucket under the seat where the resident was sitting. This was not a dignified way to transport resident #14 who was severely cognitively impaired and unaware of how he was being taken to his room. 2. The re-admission MDS, dated 7/6/06, for random resident #24 documented that she needed extensive assistance for transfers and all of her ADLs, including hygiene. On 8/9/06 at 8:30 am, the resident was observed in the dining room. She was seated at a table with two other residents waiting for her breakfast. Her hair was observed to be matted and very messy. The surveyor asked another surveyor in the dining room to look at the condition of the resident's hair. The other surveyor concurred that resident #24 had messy and matted hair. The resident did not have her dignity respected when she was sent to the dining room with uncombed hair. She was unable to perform this task herself. 3. On 8/8/06 at 7:15 am, a CNA was observed entering resident #11's room without knocking. The resident was in the room, lying on his bed	F 241	II. Staff have been inserviced on resident rights by the Social Services director and/or designee. LN and CNA staff were inserviced on resident grooming and privacy and dignity during transportation in hallways by the SDC. Resident rights will be inserviced to staff quarterly by Social Services director and/or designee. III. Dining room supervisors will ensure all residents are properly groomed when in the dining room for meals. RCM's will conduct random rounds to monitor resident care is provided with respect and dignity. Findings will be forwarded weekly to the DON for review.	

angela Peterson
9-1-06

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F 241	Continued From page 4 with his eyes closed. 4. On 8/8/06 at 7:45 am, a CNA was observed entering resident #4's room without knocking. The resident was in the room, lying on her bed with her eyes closed.	F 241	IV. The DON will present findings to the PI committee for analysis and performance improvement opportunities. V. The ED will ensure compliance. VI. Completion Date: 9/18/2006 OK BF	
F 253 SS=B	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined the facility failed to ensure a sanitary and orderly environment was provided for all residents living on the 300 unit, and all residents utilizing the activity room. Several floor tiles were cracked, shower grout was discolored, and a counter surface was damaged and unable to be properly sanitized. The findings include: During general observations of the facility on 8/08/06 at approximately 7:00 am, the following were noted: 1. There were at least 5 dime to quarter sized holes in the surface of the counter top next to the sink in the activity room. The holes exposed the wood underneath and created an uncleanable surface. The seam between the counter and the back splash was taped with a plastic like product. The tape was peeling and was soiled.	F 253	I. The areas noted potentially affect all residents. II. The floor tiles on the 300 unit that were cracked, buckling and/or dented have been replaced. The discolored grout in the shower stall on the 300 unit tub room has been replaced. The counter top in the activity room next to the sink has been replaced and the seam between the counter and back splash is sealed appropriately.	

Angela Peterson RN
9-1-06

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F 253	Continued From page 5 2. The shower stall in the 300 unit tub room contained discolored grout between the floor and the back wall of the shower. The discolored portion of grout was approximately 1 foot in length and was gray in color. 3. Multiple 12 inches x 12 inches floor tiles in hallways, nurses station, and the day room on the 300 unit were cracked, buckling, and dented. The maintenance supervisor, stated on 8/09/06 at 1:30 pm, the floor tiles were cracking/buckling due to moisture and sub-floor problems and were continually in need of repair and replacement. The maintenance supervisor explained that he was constantly inspecting the floor and tiles were removed and replaced before they became a slip/trip/fall hazard.	F 253	III. Floor tiles within the facility that are cracked, buckling, and/or dented will be replaced as identified. Countertops have been evaluated to determine the need for repair and/or replacement. Facility will repair and/or replace countertops as identified. IV. The Maintenance Director will ensure compliance through inspections of areas. Results of audits/ findings will be reviewed during performance improvement meetings and appropriate plans of action will be developed when appropriate. V. The Executive Director will monitor for ongoing compliance. VI. Completion Date: 9/18/2006 OK bf	

9-1-06

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F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, staff interview, and record review, it was determined that 1 of 23 sampled residents (#8) did not have their care plans reviewed and revised concerning the removal of an indwelling catheter and the current toileting needs. The findings include: 1. Resident #8 was admitted to the facility on 7/03/06 with diagnoses of urinary tract infection and status post cerebral vascular accident with left sided weakness. The care plan dated 7/12/06 indicated the resident had been identified with the problem of "Altered urinary elimination pattern R/T [related	F 280 F 280	I. Resident #8 care plan has been reviewed and updated. II. Resident care plans have been reviewed and there were no other findings. III. LN's were inserviced on care plan updates by the DON and/or designee. Resident care plans will be reviewed during resident care meetings by the IDT team at least quarterly and when needed. Random audits to verify care plan accuracy will be done by RCM's and forwarded to the DON weekly for review. IV. The DON will present findings to the PI committee for analysis and performance improvement opportunities. V. DON will monitor for compliance. VI. Completion Date : 9/18/2006 OK/BF	

angela Peterson 9-1-06

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F 280	Continued From page 7 to] use of Foley catheter due to : obstructive uropathy." The "Urinary Incontinence Assessment," dated 7/10/06 indicated the resident had 16 french Foley catheter with a 10 cubic centimeter balloon. The 30 day Medicare MDS, for the assessment date of 7/31/06 indicated the resident had an indwelling catheter and required extensive, 1 person assistance with transferring, toileting, and personal hygiene. On 8/08/06 at 6:45 am, the resident was observed to be up in a wheelchair, doing his own morning cares at the sink in his bathroom. A Foley catheter could not be visualized. On 8/08/06 at 8:30 am, the resident explained to the surveyor that he had the Foley catheter removed a few days ago. The resident stated, "It didn't hurt at all when the nurse took it out." The resident explained that he had some problems urinating but it was getting easier. The resident indicated it was easier to use the urinal in bed than to stand up and use it. The resident stated, "My bladder forgot how to work." On 8/08/06 at 8:55 am, the resident was observed in the bathroom, standing up by the toilet stool with the wheelchair behind the resident. The resident was yelling out, "Where's the urinal, where's the urinal!" A LN came into the bathroom and assisted the resident. On 8/9/06 at 9:30 am, the DON was asked to find the faxed physician order for the catheter removal. At approximately 10:30 am, the DON	F 280		

angela Peterson RD
9-1-06

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F 280	Continued From page 8 had a copy of the faxed physician order to have the Foley catheter discontinued. The faxed order was signed on 8/02/06. On 8/10/06 at approximately 12:00 pm, the DON was told about the care plan not being updated concerning the Foley catheter. The care plan was the road map utilized by care givers to provide consistent and appropriate care. It had not been updated to reflect the Foley catheter had been discontinued and that a resident requiring extensive assistance with toileting had been properly care planned for his current toileting needs. This is a Repeat Citation from the Recertification/Complaint Survey of 6/28/05.	F 280		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility did not ensure care plans for 1 of 23 sample residents (#19) was developed to meet the resident's identified needs based on a comprehensive assessment of the individual and	F 309	**F 309** I. Resident #19 care plan was reviewed and revised. II. Resident care plans were reviewed and updated to reflect each individuals needs with measurable goals, appropriate time frames and individualized interventions.	

angie Peterson RD
9-1-06

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F 309	Continued From page 9 included interventions, measurable objectives and timetables. Findings include: Resident #19 was admitted to the facility on 8/1/06 with diagnoses of septicemia, hyponatremia, chronic airway obstruction, hypertension, persistent mental disorder, congestive heart failure and atrial fibrillation. The initial care plan identified the following problems with respective dates: "...UTI [urinary tract infection] Chronic 8/7/06, ADL [Activities of Daily Living] Decline 8/1/06, Safety Risk 8/1/06, Cognitive Decline 8/1/06..." The care plan did not have interventions, measurable objectives or goal dates for the identified problems. On 8/10/06 at 9:25 am, the LN for the unit explained that it was an oversight that interventions, measurable objectives and goal dates were not documented on the care plan. This is a Repeat Citation From the Recertification/Complaint Survey of 6/28/05.	F 309	III. LN's were inserviced on resident care plans reflecting individualized needs with measurable goals, appropriate time frames and individualized interventions by DON or designee. Random audits to verify care plan accuracy will be done by RCM's and forwarded to the DON weekly for review. IV. The DON will present findings to the PI committee for analysis and performance improvement opportunities. V. DON will ensure compliance. VI. Completion Date : 9/18/2006 ok bk	

angela Peterson RN
9-1-06

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	135122	A. BUILDING _____ B. WING _____	08/11/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 314 SS=D	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review it was determined the facility did not ensure a Stage II pressure sore was prevented for 1 of 5 sample residents (#14) reviewed for pressure sores. Findings include: Resident #14 was admitted to the facility on 12/8/03 with a diagnosis of Alzheimer's disease. The resident's quarterly MDS, dated 7/26/06, documented he was severely cognitively impaired and required total assistance by staff for bed mobility, transfers and all ADL care. An additional "Braden Scale for Predicting Pressure Sore Risk" was completed 7/24/06. The resident was scored an 11 (10 -12 = High Risk). The care plan was dated 2/9/06 and had multiple revision dates on it. A problem identified, "Actual for alt[eration] in skin integrity: Hx [History] of pressure areas, incontinence, impaired mobility, scoots in chair, braces on legs...knee contractures...shearing buttocks...dependent for repositioning changes/transfers..." Approaches included, "...Reposition in w/c [wheel chair] prn	F 314	**F 314** I. Resident #14 reviewed. Braden skin assessment updated. Care Plan updated to reflect current problems, contributing factors, goals and individualized interventions. II. Residents have been reviewed and Braden skin risk assessment completed. Care plans reviewed for accuracy and updated. III. LN's inserviced on prevention, assessment, treatment of pressure ulcers and documentation requirements per LCCA skin program by DON and/or designee. CNA's inserviced on prevention of pressure ulcers, use of adaptive equipment, and pressure relieving approaches by SDC.	

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F 314	Continued From page 11 [as needed] scooting/mobility to recognize importance of repositioning to prevent skin breakdown..." An approach added on 7/12/06 indicated, "Heel lifts while in bed." A new problem was added, dated 7/26/06, "Stage II pressure ulcer L[eft] ankle." The approach documented was, "...Tx [Treatment] per MD [Medical Doctor] order... Nurse progress notes contained the following documentation: 7/27/06, (6:00 pm) - "During routine skin check pt [patient] found to have abraded [sic] area to L[eft] medial malleolus. Considered St[age] II d/t [due to] area over bony prominence. Pt. denies pain. Area is in location where pt able to come in contact [with] other foot when in w/c.. Leg rests to w/c are padded [with] bucket inserts to [decrease] pt from skin to skin contact - Pt wears socks & contact can be made when [up] in w/c requiring positioning of LE [lower extremities]. Pt wears foam boots when in bed. Pt. also has abrasions to ventral, dorsal R[ight] shoulder. Pt. does have ability to reach & scratch self. Will monitor areas until resolved. Family aware." The following physician telephone orders were documented: 7/28/06- "OK for 3M or Skin prep- Apply [every] daily to L malleolus until resolved. St II." 7/30/06 (2:15 pm)- "Heel protector boots on BLE's [both lower extremities] while in bed. Monitor Monitor Stage I [this had already been staged at a II] to L medial mallous [sic]." The resident was observed on 8/8/06 at 6:40 am. He was assisted with his morning ADL care and then transferred by Hoyer lift to his wheel chair.	F 314	IV. RCM's will audit weekly skin check documentation and forward audits to DON weekly for review. Resident rounds to ensure use of and effectiveness of preventive measures will be done by the RCM's and audits forwarded to the DON weekly for review. DON will report findings of audits to PI committee for analysis and performance improvement opportunities. V. DON will ensure compliance. VI. Completion Date: 9/18/2006 OK BK	

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F 314	Continued From page 12 There were two foam egg crate type boots lying in the resident's recliner. The two aides assisting the resident were asked when he wore the boots. They indicated he wore them when he was in bed. They said that restorative usually came and put his braces on his legs. It was observed that his wheel chair had arm bolster pads, a seat cushion and a black vinyl covered positioning device for each of his feet to fit into. After he had been properly positioned in the wheel chair his lap was covered with a blanket and he was taken to an area by the nurses' station. The resident remained up in his wheel chair. His spouse was observed feeding him at 8:15 am. The spouse was interviewed at the time and stated she made sure everything was taken care of when he laid down and before she left. She was observed wheeling him outside at 10:07 am. The resident was observed shortly after he was laid down in his bed at 11:10 am. He was on his left side and his boots were no longer in the recliner. On 8/10/06 at 11:15 am, the DON was asked if she could determine what had caused the Stage II as the documentation in the record had not indicated how resident #14 developed the pressure sore. She stated, after looking at the chart with the surveyor, she would get another nurse to help her and look at it. A short time later the DON came to the surveyor with another LN. The LN stated, "I know exactly how it happened." She went on to explain that when the resident got agitated while in his wheel chair he was able to get his legs in a position so he would raise and lower one leg rubbing it against the other leg. When asked if he could get his legs out of the foot bucket pad on his foot pedals, she indicated he could. She stated it was really an abrasion and	F 314		

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F 314	Continued From page 13 not a pressure sore. The facility had knowledge of a behavior symptom for repetitive movement of his legs, when the resident was agitated, and did not care plan to decrease or eliminate the behavior. The bucket inserts for his feet and socks with long pants were not effective in preventing the shearing of his ankle. Nothing new had been added to his care plan even though he was observed during the survey days of 8/8 through 8/10/06 to spend lots of time up in his wheel chair with his spouse keeping him company. The resident developed a Stage II pressure sore in the facility. This is a Repeat Citation from the Recertification/Complaint Survey of 6/28/05.	F 314		
F 323 SS=D	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, and record review, it was determined the facility failed to ensure the environment was free of electrical hazards for 1 of 20 (#10) sampled residents and a random resident who resided in the same room as resident #10. The findings include: 1. During observations on 8/09/06 at 1:30 pm, resident # 10's room was noted to contain 2	F 323	**F 323** I. Resident #10 has expired. II. At time of survey, all other resident rooms were audited to ensure compliance.	

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F 323	Continued From page 14 lamps, a simulated aquarium, a television, and a mini-refrigerator. All of the items were plugged into a 6 plug adaptor which was plugged into the wall socket. The adaptor and the electrical outlet were located behind a dresser. The "Resident Admission Agreement," on page 13, stated, "Due to fire and other safety concerns, the Resident/Representative agrees that appliances of any kind cannot be brought into or used within the Facility without the prior permission of the Facility's Executive Director. The Maintenance Supervisor must thoroughly check and tag all electrical equipment..." On 8/09/06 at approximately 2:00 pm, the Maintenance Supervisor was apprised of the electrical situation in resident # 10's room. The Maintenance Supervisor stated he was unaware of the use of the plug adaptor and had not examined/approved the electrical appliances. He concurred it was a hazard and would be corrected.	F 323	III. Staff have been in-serviced on appropriate electrical devices in rooms and proper devices for electrical items. Admissions staff will continue to educate family members to inform maintenance at any time new devices are brought into facility. In addition, it was discussed at family forum that families need to contact maintenance when bringing in electrical items. The Maintenance Director or assistant will check and approve electrical items for use and tag appropriately.	
F 324 SS=G	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to provide adequate supervision to residents to prevent falls. This was true for 2 of 15 sampled	F 324	IV. The Maintenance Director and assistant will ensure compliance through weekly audits of rooms for appropriately tagged electrical items. Information of trends and findings to be shared with performance improvement committee.	

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F 324	Continued From page 15 residents reviewed for falls (#s 10 and 17). Additionally, the facility failed to accurately assess a resident's fall risk. This failure to supervise and accurately assess resident #10's fall risk resulted in harm when the resident sustained a fractured hip following multiple falls. Findings include: 1. Resident #10 was admitted to the facility on 8/13/02, and readmitted on 7/4/06, with diagnoses of organic brain syndrome, hypertension, osteoporosis, senile dementia and hip fracture. The resident's quarterly review MDS assessments dated 1/11/06 and 6/25/06, indicated the resident had the following: *"Short and long term memory problems, *Moderately impaired cognitive skills, *Was easily distracted, *Had periods of altered perception or awareness of surroundings, *Had periods of restlessness, *Repetitive physical movements, *Required limited assistance of 1 person with ambulation, *Required partial physical support for balance during standing, *Had limitation in range of motion bilaterally for leg including hip or knee, *Was frequently incontinent of bladder, *Had an unsteady gait, *Fell in the past 31-180 days, *Received no physical therapy or restorative nursing care, and *The resident received antipsychotic medications for 7 days." Additionally, the resident's quarterly review MDS	F 324	V. Executive Director and Maintenance Director to monitor for compliance. VI. Completion Date: 9/18/2006 **F 324** I. Residents #10 and 17 have expired. II. Resident Fall risk assessments have been reviewed and updated. Care plans have been reviewed and updated. Fall alarms have been checked for proper functioning. Residents with alarms have been reviewed and care plans updated.	

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F 324	Continued From page 16 assessment dated 6/25/06, indicated the resident had the following: *"Wandering behaviors, *Required extensive assistance of 1 person for locomotion on the unit, and *Mental function varied over the course of the day." Resident #10's "Fall Risk" assessment on 2/11/06 documented the resident as "high risk" for falls with a score of "10". A score of "10" indicated "high risk." The resident's "Fall Risk" assessments for 4/20/06, 5/12/06 and 6/27/06 documented the resident as "Moderate Risk" for falls with scores of "8". The assessment for 4/20/06, 5/12/06 and 6/27/06, did not identify that the resident had a history of falls, was ambulatory with incontinence, had an unsteady gait, and required partial physical assist for balance as documented on the resident's 1/11/06 and 6/25/06 quarterly MDS assessments. Since 4/19/06, resident #10 sustained 3 falls. The first 2 falls led to potential for injury and the last fall on 7/2/06 resulted in the resident's transfer to the emergency room with a right hip fracture. Review of the resident's record and incident reports revealed the following summaries of falls, interventions and assessments: a. The resident's care plan dated 4/14/06 documented the following interventions for, "...Falls do {sic} to unsteady gait at times, dementia with decreased safety awareness, med[ication] use...psychotropic meds,...Falling Star Program..: *Offer assist as needed with mobility, limited assist with unsteady gait, Offer W/C [wheelchair]	F 324	III. LN's have been inserviced on fall risk assessment, fall prevention measures and supervision of resident care needs by DON and/or designee. Facility staff have been inserviced on "Falling Star" program and proper positioning of residents to prevent falls. Residents with alarms have been reviewed and care plans updated.	

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F 324	Continued From page 17 PRN [as needed],... *Have in visual contact during busy times, *Non skid footwear when OOB [out of bed],... *Falling Star Program..." b. The facility's "Falling Star Program" policy documented the following: *"...If a resident scores a 10 or above, the resident is assessed for participation in the Falling Stars...Program. The care plan is updated to reflect current fall risk status and resident specific interventions designed to reduce occurrence... *Facility staff are educated to recognize that residents participating in the Falling Stars...Program...are limited in safety awareness, have a greater potential to fall, and require more diligent supervision..." c. 4/19/06 at 1:45 pm: The resident was in her room and slid out of the wheelchair. The resident called out for help and was found sitting on the floor by staff. There were no apparent injuries to the resident. Follow-up nurse's notes dated 4/20/06 at 10:30 am, documented the resident's wheelchair brakes malfunctioned. Care plan interventions following the fall included assessing and monitoring the resident every shift for residual, assessing the resident every shift for pain, assessing for behavior changes, reminding the resident to ask for help with transferring, and inspecting the W/C for proper functioning brakes. d. 5/11/06 at 10:00 pm: The resident was ambulating in the hallway holding onto the handrail. The resident was startled by another resident's yelling and slid to the floor, landing on knees with her right leg extended backwards. There were no apparent injuries. The resident's	F 324	IV. Audits will be completed to ensure alarm placement and testing for alarm function weekly by the restorative staff and forwarded to the DON for review. A & I review completed by IDT team to ensure appropriate interventions and/or referrals are done with care plan updates to reflect changes. RCM's will do random rounds to ensure preventative measures and resident positioning follows care plan and forward findings to DON for review. DON will bring audit findings to PI committee for analysis and identification of performance improvement opportunities. V. DON to ensure compliance. VI. Completion Date: 9/18/2006 OK bk	

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F 324	Continued From page 18	F 324		

care plan update on 5/12/06 documented, "Resident shall have [no] problems R/T [related to] fall." There were no interventions included in the care plan up-date for this fall.

e. 7/2/06 at 1:30 pm: The resident, who was using a wheelchair at the time, sustained an unwitnessed fall in the dining room. A staff member heard a "thump" and found the resident lying on the floor on her right side. The resident was crying out in pain. The resident was then transferred to the emergency room for evaluation of right hip pain.

f. The resident's radiology report dated 7/2/06 documented, "...Impression: Nondisplaced fracture involving the intertrochanteric portion of the right femur..."

On 8/9/06 at 1:50 pm, the DON was interviewed regarding the fall prevention interventions which were in place prior to each of the resident's falls, and changes in care plan interventions following each fall. The DON indicated that increased supervision such as 1:1 supervision was used by the facility for residents who were constantly attempting to stand or transfer without assistance, or if there was a concern for other residents' safety. The DON indicated that resident #10 had not met this criteria. The DON acknowledged the fall assessments were inaccurate.

On 8/9/06 at 3:25 pm, the DON and the facility's nurse consultant provided documentation of added interventions and changes to the resident's care plan following each fall. The care plan dated 4/14/06 contained handwritten interventions and changes as follows:

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*"7/6/06 D/C [discontinue] skid rug next to bed,
*7/6/06 High/low bed,
*7/6/06 Mats at bedside,
*7/6/06 Mobility alarms to bed, and w/c if applicable,
*7/12/06 Two assist for mobility/transfers, and
*7/12/06 W/C when OOB [out of bed]."
These interventions were not put into place until after the 7/2/06 fall, which resulted in the resident's right hip fracture.

Resident #10's 1/11/06 and 6/25/06 quarterly MDS assessments documented the resident had multiple conditions which put her at increased risk for falls. Care planned interventions were based upon inaccurate assessments of the resident's needs. The facility failed to identify and implement effective preventative measures which resulted in harm when resident #10 had 3 falls from 4/19/06 through 7/2/06, including the last fall which resulted in a right hip fracture.

2. Resident #17 was admitted to the facility on 7/12/06 with diagnoses of Alzheimer's disease and after care for a fractured hip.

The resident's history and physical, dated 6/19/06, documented, "The patient is a chronically ill...woman with severe Alzheimer's dementia...and has a history of recurrent mechanical falls...She had a witnessed mechanical fall...the afternoon of June 19, 2006, and complained of right leg and hip pain...She was transported to the...Emergency Room where she was noted to have a intertrochanteric hip fracture..."

The admission MDS, dated 7/19/06, documented

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the resident was total assist for bed mobility and transfers, sustained falls in the past 30 days, past 31 - 180 days and a hip fracture in the past 180 days. An additional "Fall Risk Assessment" form was completed on 7/12/06 with a score of 14 (10 or above = High Risk). The form documented an additional assessment completed on 8/9/06 and scored the resident as "16".

The resident's care plan dated 7/21/06, identified a problem, "Risk for falls R/T [related to]: Resident with hx [history] of multiple falls...Alzheimer's..." The goal was, "Will have no serious falls in next 90 days" Approaches included, "Non skid foot ware [sic] when OOB [out of bed]. Mobility alarms to bed and w/c [wheelchair]. Falling star program. Encourage resident to wear fall guards. Assist to lay down between meals as resident willing. At nurses discretion she may initiate: Q [Every] 15 or 30 minute checks, 1:1, direct line of sight."

During the initial tour of the facility on 8/7/06 at 3:35 pm, resident #17 was identified with a hip fracture and a failed surgical repair. The nurse touring with the surveyor indicated another surgical procedure was not indicated for the resident. The resident was observed on 8/10/06 at 10:40 am. She was located at the end of her hall (away from nurses' station) and her privacy curtain was pulled between her bed and her roommate's bed. Resident #17's bed was next to the window. She was not observable from the hall door way to her room. The surveyor knocked and resident #17's roommate gave permission for the surveyor to enter. The roommate had a rubber mat next to the right side of her bed. Resident #17 was in her bed on her back, with the head of

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 324	Continued From page 21	F 324		

the bed slightly elevated, and a couple of pillows under her head. She appeared asleep. There was a rubber mat on the floor. The mat was directly below the privacy curtain and between the two residents' beds. Resident #17's bed was not against the wall and there was a gap of about 2-3 feet from the wall. The resident was observed again at 11:05 am. At this time the privacy curtain was open and the roommate was no longer in the room. Resident #17 was still lying on her back in bed. Her head and right shoulder had started to slip off the right side of the bed closest to the wall. She looked as though she was ready to slip out of the bed. A bath aide then entered the room. She asked the surveyor if she knew where the resident's aide was. The bath aide said she needed to give the resident a shower and needed help to get her up. An aide came by the door and the bath aide asked where the resident's aide was. The aide replied, "On break." The bath aide asked for help to get the resident up. The bath aide went over to the resident and cranked the bed down and then removed a pillow from under resident #17's head and moved her back on the bed. The resident did not awaken. The bath aide asked the resident, "Do you want a shower?" The resident did not respond. The surveyor then asked the bath aide if the resident had a pressure alarm on her bed. The bath aide looked and said, "No." The bath aide checked for an alarm on the resident's wheelchair and could not find one. The bath aide asked another aide that came in the room if the resident used alarms. The aide indicated the resident did not have alarms and that she did not move out of bed. The resident was at high risk for falls as assessed by the facility. Her call light had been clipped to the cover over her chest area, however, the resident

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	135122	A. BUILDING _____ B. WING _____	08/11/2006

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F 324	Continued From page 22 was not cognitively able to use it effectively. She did not have alarms in place, as care planned, to alert staff if she started to fall. This is a Repeat Citation from the Recertification/Complaint Survey of 6/28/05.	F 324		
F 328 SS=D	483.25(k) SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, grievance file review, and medical record review, it was determined the facility failed to ensure proper respiratory care was provided for 2 of 6 sampled residents (#16 & #20) and 2 unidentified residents who wished to remain anonymous but voiced concerns. The findings include: 1. Resident #20 was admitted to the facility on 2/08/02 and readmitted on 10/01/03, with diagnoses of Alzheimer dementia, chronic obstructive pulmonary disease, deep vein thrombosis, and status post gastrointestinal	F 328	**F 328** I. Residents #16 & 20 care plans have been reviewed/revised. II. Residents with oxygen orders have been identified and care plans reviewed for accuracy. III. LN's and CNA's were inserviced on liquid oxygen tank filling and appropriate times for use of portable oxygen or concentrator.	

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F 328	Continued From page 23 bleeding. The July 2006 physician recapitulated orders indicated the resident was toreceive oxygen via nasal cannula at 2 to 3 liters per minute. On 8/10/06, resident #20 was observed from 8:35 am to 8:55 am, in the dining area of the closed unit. The resident was eating breakfast. The nasal cannula was noted to be under the resident's chin. At 9:50 am, of the same day, the resident was observed to be in bed. The nasal cannula was noted to be in a plastic bag at the bedside. On 8/10/06 at approximately 9:50 am, a RN and CNA were asked, by the surveyor, if the oxygen should have been on the resident. Both stated the oxygen should have been and placed the nasal cannulas into the resident's nose. 2. Resident #16 was admitted to the facility on 7/2/06 with diagnoses of after care for pulmonary emboli, chronic dyspnea, anxiety, hypertension, depression and diabetes mellitus. The physician orders recapitulation (RECAP) for August 2006 contained an order for "O2 at 2L/Min to keep SATS > 90% [2 liters a minute to keep oxygen saturation levels above 90%]." The resident was observed on 8/10/06 at 8:15 am in her room after breakfast. She was talking to the activity director. The surveyor returned to the resident's room at 10:55 am, and observed she was seated in a wheel chair in her room. She was noted to have a portable oxygen tank on the back of her wheel chair and a nasal cannula in her	F 328	IV. RCM's will do random rounds to ensure that residents with oxygen have sufficient oxygen in portable tanks and are using oxygen when ordered. Audits will be forwarded weekly to the DON for review. DON will bring audit findings to PI committee for analysis and identification of performance improvement opportunities. V. DON will ensure compliance. VI. Completion Date: 9/18/2006 OK bk	

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F 328	Continued From page 24	F 328		

nose. The surveyor asked for permission to check the flow rate on her oxygen. It was noted that she had an oxygen concentrator in her room next to her bed. It was running but the resident had not been hooked up to the concentrator. When the surveyor checked the resident's portable tank it was set at 2 L per minute. The surveyor then lifted on the straps of the portable tank to check the level of oxygen left in the tank. The indicator needle was directly on the line between the green area indicating there was oxygen in the tank and the red area indicating it was empty. The surveyor asked the resident if she could feel any oxygen coming out of her cannula. She took the cannula out of her nose and held it in front of her lips. She said she could not feel anything. The surveyor advised the resident that staff would be asked to help her. The surveyor was directed to a nurse and then asked the nurse to come and look at the resident's oxygen. The nurse pulled up on the strap of the portable tank and agreed the oxygen was about gone. An aide then came into the room and helped the nurse. They changed the resident over to the concentrator.

3. Prior to attending the group interview with residents, the surveyors reviewed the grievance file. On 7/11/06, a family member filed a concern about oxygen. The grievance stated, "1. At night, resident puts self to bed. Not turning on O2 [oxygen] when CNA's/Nurse makes rounds. 2. Also, during the day, tank is not being filled. Resident doesn't pay attention & when son visits, tank is empty at least 75% of the time." The grievance form indicated a staff person from social services had been notified of the grievance.

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F 328	Continued From page 25 During the group interview with 20 residents and 1 family member, on 8/09/06 at 10:45 am, concerns about oxygen were brought to the attention of the surveyors. Two residents, who wished to remain anonymous, stated that oxygen containers would frequently run out and they were concerned the staff did not know how to refill the liquid oxygen containers.	F 328		
F 441 SS=E	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, it was determined the facility did not maintain an ongoing infection control program when staff did not follow appropriate infection control procedures when clean gloves where stuffed back into the box and clean gloves were placed on a wet sink prior to use. In addition, 6 of 23 sampled residents (#s 2, 9, 13, 15, 16 & 18) were not up to date with either the flu and/or pneumococcal vaccines. The findings include:	F 441	**F 441** I. Residents #2, 9, 15, 16 and 18 have been offered pneumococcal vaccination and their immunization records updated. Resident #13 is deceased. II. All other resident charts were reviewed to ensure residents were offered the pneumococcal vaccination and immunization records were updated. Standing orders for influenza and pneumococcal vaccines have been initiated for all new admissions.	

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F 441	Continued From page 26 The Centers for Disease Control and Prevention (CDC) recommends the use of standing orders programs to increase adult immunization rates for influenza and pneumococcal vaccines. The CDC factsheet addressing the standing orders protocol was sent to all Idaho nursing facilities along with informational letter #2000-13 on 10/12/00. In the factsheet, CDC stated, "...In nursing homes, hospitals, and other institutional settings, standing orders programs for influenza and pneumococcal vaccination of adults aged [greater than or equal to] 65 are effective in raising vaccination coverage levels among this population, which overall are well below national goals...Annually in the United Stated, pneumococcal disease accounts for an estimated 3,000 cases of meningitis, 63,000 cases of bacteremia, up to 175,000 hospitalized cases of pneumonia, and up to 12,5000 deaths due to pneumococcal pneumonia in hospitalized patients. Despite antimicrobial therapy and intensive medical care, the overall case-fatality rate for pneumococcal bacteremia is 15% - 20% among adults...The 1997 National Nursing Home Survey estimated influenza and pneumococcal vaccination of residents in long-term care facilities of 64% and 28%, respectively...well below the Health People 2000 objective of 80% for both vaccines in persons in such institutions...Standing orders programs authorize nurses and pharmacists to administer vaccinations according to an institution or physician approved protocol without the need for a physician's exam..." 1. Resident #9 was admitted to the facility on 11/30/05 with diagnoses of decubitus ulcer and status post cerebral vascular accident.	F 441	III. LN staff and SDC were inserviced on standing orders for influenza and pneumococcal vaccines and documentation on immunization record. Facility staff inserviced on glove use/disposal and hand hygiene. IV. Handwashing/glove use will be audited randomly by SDC and forwarded to DON. SDC will audit new resident medical records to ensure vaccinations are offered and documented on immunization record and forward audits to DON for review. SDC will present audit findings to the PI committee to identify opportunities for performance improvement. V. DON will ensure compliance. VI. Completion Date : 9/18/2006 OK bf	

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F 441	Continued From page 27 The recapitulated physician orders for July of 2006, indicated the physician had ordered the flu and pneumococcal vaccine on 11/30/05. The MDS with the assessment date of 5/39/06 indicated neither the flu or the pneumococcal vaccine had been offered. On 8/09/06 at 1:45 pm, the DON was asked to locate the documentation of the flu and pneumococcal vaccine. The DON indicated she would look for the documentation and stated, "I know we have problems with this." On 8/10/06 at 7:30 am, the DON stated she could not find the documentation. During the exit conference on 8/11/06 at 8:00 am, the vaccine documentation had not been found. The facility was told to submit any vaccine documentation they could find by the end of the working day on Monday, 8/14/06. 2. Resident #15 was admitted to the facility on 5/18/06 with diagnoses of status post fall with bilateral shoulder impingement and end stage chronic obstructive pulmonary disease. The August 2006 physician recapitulated orders indicated the physician had ordered the resident to have the pneumococcal vaccine on 5/18/06. The MDS with the assessment date of 5/25/06 indicated the resident's pneumococcal vaccine status was up to date. Review of the medical record found no documentation the pneumococcal vaccine had	F 441		

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F 441	Continued From page 28 been given. On 8/10/06 at 11:50 am, the DON stated the pneumococcal vaccine had not been given. 3. Resident #18 was admitted to the facility on 6/29/06 and readmitted on 7/24/06 with diagnoses of pneumonia, malnutrition, and status post cerebral vascular accident. The July 2006 physician recapitulated orders indicated the physician had ordered the resident to have the pneumococcal vaccine on 7/24/06. The MDS with the assessment date of 7/31/06 indicated the pneumococcal vaccine had been offered and declined. Review of the medical record found no documentation of the declination or that consultation had been provided if the resident had refused the vaccine. On 8/10/06 at 11:50 am, the DON stated the vaccine should have been given but was not sure why it wasn't. The DON acknowledged there was no documentation that the resident had declined the vaccine. 4. Resident #14 was admitted to the facility on 12/8/03 with a diagnosis of Alzheimer's disease. The resident's quarterly MDS, dated 7/26/06, documented he was severely cognitively impaired and required total assistance by staff for all ADL care.	F 441		

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F 441	Continued From page 29 The resident was observed on 8/8/06 at 6:45 am, while he received morning ADL care. Two aides provided his care. The resident was seated in a shower/toilet chair and wrapped in a bath blanket. Both of the aides put gloves on after using hand sanitizer. One of the aides combed his hair. They transferred the resident by a Hoyer lift to his bed where they dressed him. After he was dressed one aide stuffed some soiled linen into a plastic bag and removed her gloves. The same aide went into the bathroom and reached into a box of gloves contained in a dispenser on the wall above the sink. Several (at least 5) gloves came out and the aide stuffed all but two back into the box. She then laid the latex gloves over the sink edge, which was water splashed, while she washed her hands. She dried her hands and put the gloves on and proceeded assist the resident with the Hoyer lift and transfer him to his wheel chair. She helped position him in the wheel chair and covered his lap with a blanket. She then washed the residents glasses and placed them on him. She removed her latex gloves and used hand sanitizer before pushing the resident out of the room and into the hall by the nurses' station. The aide did not ensure that sanitary gloves were used before contact with the resident and also contaminated the clean gloves after putting contaminated gloves back in the box. 5. Resident #2 was admitted to the facility on 11/30/06. The admission MDS, dated 12/7/05, documented the pneumococcal vaccine (PPV) had not been offered to her. The July 2006 physician orders documented, "...Offer pneumovac on admission inil [initial] when done and place on immune sheet.11/30/05..." There	F 441		

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F 441	Continued From page 30 was no record of the PPV on the immune sheet. The DON indicated during interview on 8/8/06 at 12:55 pm, that the facility was giving the PPVs that week. 6. Similar findings for PPVs not offered or given included residents #13 and #16. This is a Repeat Citation from the Recertification/Complaint Survey of 6/28/05.	F 441		

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C 000	INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited at the annual recertification survey at your facility. Surveyors conducting the annual survey were: Barb Franek, RN, BSN, COHN-S Team Coordinator Lorna Bouse, BSW Lea Stoltz, QMRP Kim Heuman, RN Tom Snyder, RN Survey Definitions: MDS = Minimum Data Set assessment RAI = Resident Assessment Instrument RAP = Resident Assessment Protocol DON = Director of Nursing LN = Licensed Nurse RN = Registered Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record	C 000	Called @ 1030, 9/12/06 Spoke = DON. OK to write that State POCs are same as federal. BF	
C 125	02.100,03,c,ix ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; This Rule is not met as evidenced by: Please refer to F241 as it relates to dignity for	C 125	POC Same as F241 RECEIVED SEP - 5 2006 FACILITY STANDARDS	

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C 125	Continued From page 1 privacy and for personal needs.	C 125		
C 361	02.108,07 HOUSEKEEPING SERVICES AND EQUIPMENT 07. Housekeeping Services and Equipment. Sufficient housekeeping and maintenance personnel and equipment shall be provided to maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner. This Rule is not met as evidenced by: Refer to F253 as it related to cracked floor tiles, discolored grout, and a damaged counter top on the 300 unit.	C 361	POC Same as F253	
C 434	02.120,10,c c. Plug adaptors and multiple outlets are prohibited. This Rule is not met as evidenced by: Refer to F323 as it related to the use of a plug adaptor creating an electrical hazard.	C 434	POC Same as F323	
C 669	02.150,03 PATIENT/RESIDENT PROTECTION 03. Patient/Resident Protection. There is evidence of infection control, prevention and surveillance in the outcome of care for all patients/residents as demonstrated by: This Rule is not met as evidenced by: Refer to F441 as it related to the maintenance of infection control procedures concerning the handling of clean gloves, and the flu and pneumococcal vaccines.	C 669	POC Same as F441	

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C 778	Continued From page 2	C 778		
C 778	02.200,03,a PATIENT/RESIDENT CARE 03. Patient/Resident Care. a. A patient/resident plan of care shall be developed in writing upon admission of the patient/resident, which shall be: This Rule is not met as evidenced by: Refer to F309 as it related to initial care plan issues for resident #19.	C 778	POC Same as F309	
C 782	02.200,03,a,iv iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Refer to F280 as it related to a care plan for resident #8 not being revised.	C 782	POC Same as F280	
C 788	02.200,03,b,iv iv. Delivery of medications, diet and treatments as ordered by the attending physician, dentist or nurse practitioner; This Rule is not met as evidenced by: Refer to F328 as it related to oxygen not being administered per physician's orders.	C 788	POC Same as F328	
C 789	02.200,03,b,v v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or	C 789		

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C 789	Continued From page 3 wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by: Please refer to F314 as it relates to prevention of pressure ulcers. Refer to F314 as it related to prevention of pressure ulcers.	C 789	POC Same as F314	
C 790	02.200,03,b,vi vi. Protection from accident or injury; This Rule is not met as evidenced by: Please refer to F324 as it relates to prevention of accidents or injury. Refer to F324 as it related to fall prevention.	C 790	POC Same as F324	

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